Personal View

Since arriving in Canada three and a half years ago it has been an interesting experience to see the country facing the same health care problems which have faced us in Britain for the last 20 years. Simply stated, these are the problems of meeting unlimited demands with limited resources. Developed countries seem now to be following a law of convergence so far as their health care systems are concerned: the differences between them become less and less every year. On reflection, this is not surprising, since the same influences are at work in all these countries. Firstly, health care has been recognized as a citizen's right. In Canada, this recognition has come gradually, province by province—beginning with Saskatchewan in 1963 and ending with Quebec in 1970. Whatever the rights and wrongs of this principle, it is obviously here to stay. Its consequences are an increase in demands for service and an acceptance by government of the responsibility for providing that service.

Secondly, all countries are now facing the fact that resources are limited. This realization has come relatively late in Canada. The '60s were a decade of lavish spending on health services and education. Now the golden days are over, probably never to return. Being a wealthier country, Canada still has greater resources to deploy than we have in Britain. But I am convinced that from now onwards spending on health and education will be under much tighter control and will be governed by strict criteria of accountability.

* * *

Many consequences flow from these conditions. Since government is responsible for providing, distributing, and financing health services, health care is brought into the area of political decision making. Government becomes concerned in the allocation of resources between health, education, and other public services. It also becomes very concerned with the way these resources are used. So it can no longer tolerate the duplication of expensive services, maldistribution of physicians, or manpower-training policies which conflict with public needs.

One result of these influences has been the surge of official interest in the regionalization of health services. Of the ten provinces, only British Columbia has developed a regional administrative structure at all comparable with that of the N.H.S. Other provinces have financed and operated their hospital systems through centralized hospitals' commissions which deal directly with individual hospitals. In vast provinces like Ontario and Quebec the difficulties of this type of administration can be imagined. Now most provinces have plans for regionalization. The most far reaching of these is in Quebec, where, under the Health Minister M. Castonguay, a completely integrated system of health care—from health centres to ultra-specialized hospitals—is now being implemented. One interesting feature of the Quebec plan is the amount of government and public control at all levels of the system—a control which makes the N.H.S. look mild in comparison.

Another result has been a series of clashes between the medical profession and provincial governments on fee schedules. Doctors are paid, of course, by fee for service, a system which has from the government's point of view the serious drawback of being open-ended. Citizens pay a premium into a government insurance scheme which pays for hospital treatment and doctors' services. The schemes are not entirely financed by premiums: provincial governments contribute varying amounts from general taxation, and in two provinces the whole scheme is financed from taxes. In theory, any increase in expenditures on services can be met by increasing the premium. In practice, however, governments are under strong pressure from the electorate to reduce premiums and to subsidize medicare from taxation. Governments thus become keenly interested in the cost of doctors' services.

* * *

Under these circumstances it is hardly surprising that the fee for service system is coming under increasing pressure from government. This pressure has taken various forms. In Quebec the Castonguay Commission has recommended "that the method of payment set on a fee for service basis be progressively abandoned in favour of other forms of remuneration." The Ontario government has ruled that doctors may not bill the insurance plan for their fee, then charge the patient for the 10% of the fee not covered by the plan. It is customary for medicare to pay only 90% of the fee schedule. Doctors are entitled to collect the remaining 10% from patients but are officially discouraged from doing so. The action of the Ontario government will now leave doctors with only two alternatives: to bill the plan direct and accept 90%; or to bill the patient for 100%, but run the risk of not being paid when the patient collects the money from the plan.

The dispute at present in progress in British Columbia is perhaps the most portentous of all. Here the government has put a ceiling on expenditure under the plan. This ceiling will limit increases in expenditure on all items of medical service, including doctors' fees, diagnostic and therapeutic procedures, and increases in use. For the first time in Canada, therefore, doctors are being given the responsibility for rationing scarce resources. This responsibility was placed on British doctors by the N.H.S. and it was accepted. The doctors in British Columbia at present seem to be saying that it is a government responsibility to make decisions about allocation of resources.

* * *

Medical schools have not escaped the new demands for economy and accountability. The universities' role in training skilled manpower has come under close scrutiny and it is becoming very clear that governments will not tolerate the inconsistencies in the old system. In Ontario, for example, the government has issued guidelines which state that half of all Ontario graduates should become family doctors. There is every prospect that these guidelines will be followed.

As I witness this public regulation of medical education, I am filled with amazement that the British public and their elected representatives have tolerated for so long a system which leads to such an appalling wastage of trained manpower. Countries such as Canada have, of course, been the beneficiaries of this wastage, since the surplus of British doctors—trained for the wrong jobs and then rejected by the system—have found a ready acceptance here.

There will of course be many voices raised for academic freedom: for the liberty of universities and other academic bodies in a free society to manage their own affairs. But this is simplistic thinking. Academic freedom is not a single concept. If it is the freedom to pursue the truth wherever it leads and to express opinions without fear of persecution then the concept is incontestable. But if it is the freedom to use public funds to train professional people who are unable to serve the public need, then the concept cannot be defended. Professions exist to serve the public interest and if universities use public funds to train members of professions they must expect to be held accountable.

IAN R. McWHINNEY
Professor of Family Medicine

Loudon, Ontario, Canada